DOCUMENT RESUME

ED 471 330 CG 032 140

AUTHOR	Craig, Steven E.; Bischof, Gary H.
TITLE	Closure Issues with Families.
PUB DATE	2003-01-00
NOTE	30p.; In: Family Counseling for All Counselors; see CG 032 109.
AVAILABLE FROM	ERIC Counseling and Student Services Clearinghouse, University of North Carolina at Greensboro, 201 Ferguson Building, P.O. Box 26171, Greensboro, NC 27402-6171 ($34.95). Tel: 336-334-4114; Tel: 800-414-9769 (Toll Free); Fax: 336-334-4116; e-mail: ericcass@uncg.edu; Web site: http://ericcass.uncg.edu.
PUB TYPE	Guides - Non-Classroom (055) -- Information Analyses (070)
EDRS PRICE	EDRS Price MF01/PC02 Plus Postage.
DESCRIPTORS	*Counseling Techniques; *Counselor Client Relationship; *Family Counseling; *Outcomes of Treatment
IDENTIFIERS	*Closure

ABSTRACT

Closure of the counseling relationship constitutes both an ending and a beginning. Although closure signifies the ending of the present counseling relationship, many family counselors conceptualize closure as the start of a working relationship between counselor and family that may be summoned in future times of crisis or during a difficult life transition. This chapter discusses the common tasks of closure, including how closure in family counseling is different from closure in individual counseling, indications of a family's readiness for closure, working toward closure, elements of the closure session, innovative methods to facilitate closure, considerations after the final session, and unilateral termination, both client initiated and therapist initiated. (Contains 20 references.) (GCP)

Reproductions supplied by EDRS are the best that can be made
from the original document.

ED 471 330

Closure Issues with Families

by

Steven E. Craig
Gary H. Bischof

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

BEST COPY AVAILABLE

CG032140

Chapter Eight

Closure Issues with Families

Steven E. Craig and Gary H. Bischof

In the recently heralded book *Tuesdays with Morrie,* Mitch Albom (1997) writes about his rekindled mentorship and friendship with his college professor. Albom learned that his former professor, whom he affectionately called "Coach," had been diagnosed with a form of Lou Gehrig's disease. Though Coach's body withered away, his soul continued to grow. In the later pages of the book, to which we can do no justice in this brief paragraph, Albom talks of the days leading up to Coach's death. As he sits with Coach, Albom makes a statement that concisely describes Western culture's perspective of death: "I don't know how to say goodbye" (p. 185).

For many in our Western culture, goodbyes are awkward to say the least. Society has taught people that goodbyes are endings. As counselors, however, we are convinced that closure of the counseling relationship constitutes both an ending and a beginning. On the one hand, closure signifies the ending of the present counseling relationship. On the other hand, many family counselors conceptualize closure as the start of a working relationship between counselor and family that may be summoned in future times of crisis or during a

difficult life transition. Some (Heath, 1985; Lebow, 1995) have likened this to the relationship people share with their family doctor. People may go extended periods of time without seeing their physician, yet the relationship remains open in times of need.

Surprisingly, a review of the literature reveals sparse coverage of closure issues in family counseling. For Brock and Barnard (1999, p. 115), closure means "to end actively." The assumption is that closure, when ideally implemented, consists of a *collaborative* venture between client and therapist. Clearly, situations exist in which families may prematurely discontinue counseling for reasons including financial constraints, lack of compatibility between therapist and clients, or geographic inconvenience. But, regardless whether closure is client initiated, counselor initiated, premature, or naturally determined after problem resolution, it deserves careful consideration from counselors who work with families. Although closure may be considered the final stage of counseling, we believe that it is also a *process,* the elements of which take place throughout counseling.

In this chapter, we will discuss the common tasks of closure, including how closure in family counseling is different from closure in individual counseling, indications of a family's readiness for closure, working toward closure, elements of the closure session, innovative methods to facilitate closure, considerations after the final session, and unilateral termination, both client initiated and therapist initiated.

Common Tasks of Closure

A select group of authors (Bell, 1975; Brock & Barnard, 1999; Lebow, 1995; Papero, 1995; Treacher, 1989; Wilcoxon & Gladding, 1985) have attempted to expand counselors' understanding of closure of a family counseling relationship. Lebow (1995) provides a comprehensive description of the closure process for family counselors that we have found especially helpful. His closure tasks and a brief description of each follow:

1. **Track progress.** You spend considerable time defining goals for the counseling process with your clients. Before

closure can occur, you and your clients must collaboratively assess the degree to which treatment goals have been achieved.

2. **Review the course of counseling.** Lebow considers this task to be a continuation of tracking the family's progress. In this step, you assist family members in reviewing the major events of counseling, encouraging them to share their perceptions of those things that have been most and least helpful. This task also allows counselors to share their perceptions as well.
3. **Highlight gains**. Families who achieve their stated goals often give the credit to their counselor and neglect to recognize their role in the success. It is important to make a concerted effort to highlight the gains the family made during counseling and to credit these changes to the efforts of family members.
4. **Generalize learning to the "real world."** Lebow suggests that family counseling is most effective when family members are able to apply the skills they have learned to real-life situations. These skills may include behavioral skills (assertiveness), affective skills (working through grief), or psychodynamic skills (insight about themselves). Assist families in developing a maintenance plan that will ensure they will continue practicing the skills following closure.
5. **Internalize the therapist.** Throughout counseling, family members will often discuss among themselves what they believe you might say or do when they are facing a dilemma. During the closure process, encourage clients to practice this skill so that they will have internalized some of your perspectives and ideas by the time the counseling relationship ends. Families who receive constructive feedback from you as they practice internalization are likely to develop confidence in their abilities to solve future problems without having to seek further counseling services.

6. **Learn from past endings.** All people have experienced endings during their lifetime. Approach the closure process with sensitivity to the various ways in which family members have experienced endings in their individual pasts, with special consideration to how these experiences might affect the closure process.
7. **Say goodbye.** Lebow considers this task one of the most difficult for counselors. Families need the opportunity to express their appreciation for your assistance and to acknowledge the attachment that has likely developed. After all, the relationship may have existed for a considerable length of time, and the family has trusted you with intimate information. Although some families may end counseling abruptly, you must still be willing to work through your own feelings and accept the family's way of ending the relationship. Ultimately, you are responsible for ending the relationship in the most positive and healthy manner possible.
8. **Discuss conditions for returning.** Assist the family in devising guidelines for their possible return to counseling. By normalizing the possibility of future difficulties, you prepare the family to expect setbacks. As such, Lebow suggests that you help families determine a set of conditions under which they would return.
9. **Make appropriate referrals.** In select cases, appropriate referrals may be warranted; for example, to a psychiatrist or primary care provider for a medication evaluation, to self-help groups, to individual counseling, or to supplemental marital therapy. You may also need to make a referral when a family's problems exceed your professional training or competence.
10. **Define your post-therapy availability.** This task is related to task 8, in which you and the family collaboratively determine the conditions for their return. It is important to make clear when and under what conditions you will be available for future consultations or sessions. For example,

if you are in private practice, you cannot necessarily guarantee that you will be available at the same time and day if the family wishes to return. Thus, the limits of your availability should be made clear during the closure phase of counseling.

Rather than viewing these tasks as a linear, strictly sequential process, Lebow (1995) suggests conceptualizing them as an agenda needing coverage during appropriate phases of counseling. We have learned that an agenda, though helpful as a guiding framework, is rarely sufficient for every family. Inevitably, families will present with unique characteristics or expectations that make strict adherence to an agenda unrealistic. As each counseling relationship draws to a close, you will not necessarily need to address all of these tasks with every family. The list is helpful to keep in mind, however, as a guideline for reaching successful closure with couples and families. Now that we have taken a look at some of the common tasks of closure, let us also review some ways in which closure in family counseling is different from closure in individual counseling.

Individual versus Family Closure

The closure process with a family presents some unique challenges that further distinguish the process of family work from individual counseling. Unlike when you counsel an individual, with a family you must contend with a number of participants and subsequently a variety of perspectives. Occasionally, family members will have discrepant views regarding their readiness to end counseling. When this happens, it is especially important to process each family member's reaction to closure of the counseling relationship and to become skillful in handling participants' discrepant views. One strategy is to negotiate a compromise among participants, a process that validates each person's perspective while also modeling effective conflict-resolution skills for the family. For example Patterson, Williams, Grauf-Grounds, & Chamow (1998) discuss a couple who disagreed on their readiness for closure. After a period of counseling, the husband felt he and his wife were communicating more effectively

and was prepared to discontinue counseling. In contrast, the wife felt she and her husband could benefit in other areas, especially their sexual relationship, and she wished to continue the weekly sessions. After validating both partners' perspectives, the counselor facilitated a compromise that resulted in sessions being continued on a biweekly rather than weekly basis. This enabled the couple to continue counseling on a less intensive basis to address issues related to their sexual relationship.

Now that you have a clearer understanding of how closure with families is different from closure with individual clients, we will discuss some more specific ways to assess a family's readiness for closure.

Indicators of a Family's Readiness for Closure

I (SEC) once had a girlfriend in the fourth grade who, upon my calling to tell her I wanted to break up with her, replied, "I didn't know we were going out." I'm certainly hopeful I establish a better relationship with my clients than I did with my first girlfriend! Aside from the damage this incident did to my ego, it illustrates an important point about the process of closure. Before you can ascertain a family's readiness for closure, you must first understand where they are going. Said otherwise, you must be clear on the family's stated goals and objectives for coming to counseling. Failure to identify goals clearly can result in an ambiguous ending that leaves both counselor and family feeling empty and dissatisfied.

The assessment of a family's readiness for closure is a vital task in family counseling. So how do family counselors determine when is an appropriate time to end the counseling relationship? To answer this question, we need to take a look at some behaviors that suggest a family is ready for closure. Most theorists, including those highlighted in chapter 3 (Adler, Perls, and Lazarus), have their own perspectives about how change occurs and how counselors can have some assurance about when to discontinue counseling. Howeve , Bell

(1975) has identified five key indicators that a family may be ready for closure of the counseling relationship, and these indicators are useful for family counselors across various theoretical foundations. According to Bell, family work is complete when the family

1. resolves or learns to cope effectively with symptoms
2. demonstrates enhanced cooperation, independence, and humor
3. displays more open styles of family interaction
4. reports increased feelings of security
5. demonstrates increased flexibility in their family roles

Treacher (1989) has devised an approach for assessing closure readiness based on Minuchin's structural theory of family therapy. According to Treacher, three questions are integral to assessing a family's readiness for closure:

1. What is the status of the family's presenting problem? (e.g., improved; worsened; improved to an acceptable level according to all participants)
2. What structural changes have taken place? (e.g., boundaries; hierarchical changes)
3. What changes in individual and family beliefs have occurred? (e.g., role definitions; overgeneralizations).

Families that indicate a resolution of the presenting problem, demonstrate positive structural changes, and display a shift in cognitive beliefs are probably ready for closure.

Other potential indicators of a family's readiness for closure lie in their observable behaviors and your personal feelings. Such client behaviors as an increase of small talk, noncompliance (no-shows, cancellations), decreased motivation, and more positive affective tone all may signal readiness for closure. We have also observed greater courage and confidence in families who are nearing the closure phase of counseling. Finally, if you are finding yourself feeling consistently bored, tired, or disinterested because the major work seems to have been completed, you may consider initiating a discussion about the family's readiness for closure.

Certainly, the preceding indicators are helpful. We have found another way of assessing the appropriateness of closure, however: We ask the family if they're ready. Because counseling is a collaborative process, and because we work under the assumption that clients know themselves better than we know them, we invite families to participate in deciding whether or not counseling will continue.

Working Toward Closure

Several strategies may be employed to ease the transition toward closure, especially in cases where the family expresses some reluctance to end counseling or where family members have discrepant views about their readiness for closure. A common approach is to increase the time between sessions to provide the family with more opportunities to implement the skills they have learned in counseling and to help them gain confidence that they can solve problems successfully on their own. Thus, if you have been meeting weekly with a family, you might suggest meeting every other week. Sometimes as therapy begins to wind down, families naturally implement this strategy by canceling or rescheduling appointments. You can reframe this phenomenon positively by suggesting to the family that it indicates less reliance upon therapy. If problems resurface as the time between sessions is extended, you can take a one-down approach and apologize for pushing the family too hard. Alternatively, you can normalize relapses by presenting them as opportunities to learn more about the problem and to develop longer-lasting solutions.

Another helpful strategy when you extend the time is to suggest that the couple or family meet on their own without you at the usual therapy day and time. This could be done at home or at some other agreed-upon neutral place. Doing so may reinforce the family's ability to solve problems independently and emphasize the value of setting aside some time to check in with one another. Clients often report talking about what their therapist might say regarding their

circumstances during their family meeting, thus highlighting the internalization of the therapy experience in their collective lives. For example, one family met at a restaurant for pizza at the usual counseling time and checked in with one another about how the past week had gone. They found doing so helpful, and on returning for their next session, reported that they would likely continue meeting periodically for pizza and a family discussion when counseling was over. Exploring successful meetings of this kind with the family can help clarify how they worked through issues on their own, and offers you opportunities to praise family members for their positive contributions. Unsuccessful meetings might indicate the need to continue regular sessions and may reveal issues that still need to be addressed.

In cases that do not involve severe problems such as violence or abuse, it is often helpful to normalize minor relapses or even to predict relapse. Presenting the natural process of change as "two steps forward, one step back" can help reassure people that a minor relapse is not a crisis. You can even ask couples to predict what their next argument will be about, or explore with a family what it would mean to them if their teenage boy stayed out past curfew and how they would handle it. Adolescents might be encouraged to test their parents' new teamwork by trying to play one parent against the other. Such strategies help to normalize setbacks and can place minor relapses in proper perspective. Discussion of these issues also allows you to emphasize the importance of handling problems effectively and that life will not be problem free. The closure of counseling also presents clients with an opportunity to share their experiences of the counseling process, and this is addressed next.

Reflective of the changing nature of the relationship between you and a family as closure approaches, you can elicit from the family perspectives on your performance and what they found useful or feel could have been improved in the counseling process. Such information enables you to improve your skills and reinforces the things you are doing well. Inviting honest feedback puts clients in the position of being experts and acknowledges that they have something to offer you. Soliciting feedback also provides an opportunity to address any

matters that that the client might have found annoying or irritating and establish a clear sense that there is no unfinished business. For counselors with little experience working with families, hearing what was helpful about the counseling or the counselor's style can bolster confidence and may increase self-efficacy.

Elements of the Closure Session: Goodbye for Now

Perhaps Carlson and Carlson (1999, p. 49) say it best, "Transitions are like speed bumps: You need to slow down while approaching them." Our experiences supervising counselors in training have shown us that many counselors have a tendency to rush the process of closure. Consider the last major transition you can recall. Perhaps it was a relocation to another city. Maybe it was a new marriage. Maybe you recently faced a divorce or a new career. Transitions are stressful experiences mentally, emotionally, and physically. The same can hold true for the closure of a counseling relationship. The primary responsibility for easing the transition lies with you.

Earlier, we referred to Lebow's (1995) tasks for the closure process. During the last few sessions before closure, many of these tasks become more prominent and important. For example, the last few sessions should include a review of treatment goals and events, an attempt to help families internalize the therapist, time to process endings and how each participant is feeling about closure, a review of gains made and the role each member played in these successes, and definition of post-treatment availability. Seligman (2001) gives five guidelines for the closure phase of counseling. Though she intended these guidelines for individual counseling, we have modified them for work with families. Let's take a look at how Seligman's guidelines may be helpful for family work:

1. Allow at least three weeks to process closure. This allows both you and family members time to share your personal reactions about the process.
2. Expect various, surprising reactions. Although many families may show little emotion at the initiation of

closure, other reactions, such as anger, hurt, or disappointment, may emerge later.

3. Expect various, surprising reactions in yourself. You too may experience different emotions related to closure and should anticipate the possibility of feeling anger, frustration, excitement, or disappointment. Personally, we can both attest to the disappointment and confusion we have experienced when some families have prematurely terminated without notice. I (SEC) recall feeling disappointed over one family's unexpected decision to discontinue counseling. For about ten weeks, I had been seeing a blended family who, in my estimation, had made significant strides but could likely benefit from continued counseling. The family called during the week to inform me that they had decided to end the counseling relationship, without giving any reason for their decision. I was confused and disappointed. Through consultation with colleagues, I became aware that my feelings were most likely a result of my own struggle to accept the family's way of ending the counseling relationship. When families terminate counseling, counselors' tendency is to personalize their decision. Experience has taught me that when this occurs, it is important to self-assess and determine whether I might have done something to thwart the process. On the other hand, it is equally important for me to consider the possibility that the family members have gotten what they need from the counseling experience and are simply ready to apply what they have learned.
4. Elicit feedback from clients about the process. Instead of asking for general feedback, attempt to elicit reactions to specific moments in the counseling experience. Because clients are often reticent to criticize, work hard to create a safe environment where clients feel comfortable enough to speak candidly about their experiences.
5. Try to leave clients with positive feelings and a sense of self-efficacy about the counseling experience.

Empowerment is crucial during the closure phase of counseling. Clients have a tendency to express gratitude during closure. Although it is important to acknowledge their appreciation, it is also crucial to find ways to return the responsibility for their success to the family members.

In the next section, we identify some creative ways to empower the family and solidify change. These are activities you might use during the last few sessions of the counseling relationship.

Innovative Methods to Facilitate Closure

The purpose of the following activities is twofold. First, they may ease the transition for all participants. Second, and perhaps most important, they provide a way to highlight the changes a family has made by allowing all the members to participate actively. Efforts to empower families during the closure process can facilitate their belief in themselves. Your encouragement may help them regain faith in themselves, recognize their strengths, and develop the "courage to be imperfect" (Dreikurs, 1967, p. 43). We have successfully used experiential activities to focus the final session on the changes made during counseling. The following examples from our clinical experiences illustrate how you might use these strategies.

Sand Tray

Several years ago, a blended family consisting of a stepfather, mother, and 14 year-old son came to see me (SEC) for counseling. After many sessions the family found that they would soon face an adjustment period when two other stepchildren would be moving into the home. The 14-year-old had reacted in ways that understandably were a concern for the parents: vandalism, defiance toward teachers and his parents, and a sudden drop in grades. Given the context of this family's situation, I decided to provide an opportunity for this family to work together on an experiential activity that could highlight some of the positive changes they had made in counseling. My instructions went something like this, "Using any of the figurines and materials available

for the sand tray, construct something that displays what you have learned during our time together." (For a detailed review of sand tray therapy, see Mitchell & Friedman, 1994). In watching the family, I noted that their level of cooperation had increased. Of special significance was the cooperation between the son and his stepfather, a relationship that until then had been largely distant because, as both parents admitted, the mother had been overinvolved and the stepfather underinvolved in the day-to-day responsibilities related to childcare.

When the family had finished, I used the following questions to highlight their presenting problem (the adolescent's misbehavior), the changes they had been able to make, and the role each family member played in resolving the problems. Only through observing the family in an activity like the sand tray could I notice these positive changes, highlight them, and subsequently encourage the family and reinforce their ability to problem solve. Similar goals can be achieved through media such as family art activities, games, and role-playing.

Here are useful questions for processing the sand tray activity:

1. If you were to provide a title for your sand tray creation, what would it be?
2. How is your creation reflective of the changes you have made?
3. If you could change one thing about your creation, what would it be?
4. When problems come up for your family in the future, how will you address them?

Sculpting

Pioneers of family therapy, such as Virginia Satir and Bunny Duhl, introduced the use of sculpting with families. Briefly, sculpting involves family members physically positioning themselves and others to represent the relationships and roles in the family. Sculpting provides an active, experiential, and often powerful means of assessment and intervention with a family. Families who have used sculpting earlier in treatment can recreate the way their family was

sculpted at the start of therapy, then all create new sculptures to represent how they see their family currently. Even if they have not used sculpting previously, they can do "before and after" therapy sculpts. Again, this strategy highlights the gains a family has made and provides a present-centered opportunity to process and underline the contributions of each family member in bringing about the positive changes. To set a future orientation, ask the family to portray ongoing changes they hope will continue or to anticipate and plan for minor relapses.

I (GHB) have also used line sculpts to depict clients' perspectives on progress in therapy. For example, using the idea of a continuum, with one side of the room representing the time before therapy started or when things were at their worst, and the other side of the room representing complete resolution of the problem, I ask family members to place themselves along the continuum to show where they see the problem now. We explore their reasons for choosing a certain spot and, true to a systems approach, acknowledge different perspectives on progress. I typically also orient the discussion toward the family's progress and what they can do both to maintain the gains and to continue progress.

As an example, I used line sculpts at the beginning and again near the end of treatment with a single mother and two teenage boys who had presented with concerns about sibling aggression and vague suicidal threats by the younger son. As closure approached, for each major problem we had addressed in counseling, the family members placed themselves along a continuum of progress. Although there were minor differences in their perspectives, the tangible difference between their positions on the continuum at the beginning of therapy versus near the end of treatment reinforced that the entire family felt significant positive changes had been made. The tone of the exercise was playful, a significant change from their affect at the beginning of therapy, and the activity also seemed to help them give themselves credit for the contributions they had made.

Football Scaling Grid

Another intervention I (GHB) have used to help a family identify progress at the end of therapy involves the use of a handout showing a representation of a football field. There is blank space on the left side for the family to write down the goals or problems that have been the focus of therapy. To the right is the football field, marked off in 10-yard intervals, with an end zone on the far right, representing a "touchdown"; that is, resolution of a problem or full attainment of a goal. Family members indicate where they were on each presenting problem when they came in and where they are now. I encourage them to jot down what they or others have done to accomplish change and, for partial successes, to identify what would help them advance a bit farther toward resolution of the problem or attainment of the goal. This variation of the scaling question used in solution-focused therapy approaches provides an enjoyable pictorial means to summarize the gains made in treatment. Typically, family members feel encouraged when they see this visual representation of the progress they have made, even though most don't reach a touchdown for all their issues. You could give out a handout like this for family members to complete independently as a homework assignment prior to the final session. I have also done a similar intervention on a chalkboard or dry-erase board, having various family members indicate their perspectives using different symbols or colors.

I used this strategy with a family of four who had presented with complaints that the teenage daughter was defiant and disrespectful to her parents and had frequent hostile conflicts with her younger brother. The family was involved in various sports and seemed to like visual images, so I opted to use the football scaling grid in our final session as a way to highlight the considerable gains they had made and identify how they could maintain and further the work they had done. In advance of the session, I drew a football field on a dry-erase board and identified the major areas we had focused on in counseling. In the session, I gave each family member a different colored marker and, for the various problem areas, they rotated the

order in which they marked their perspectives. I encouraged them to think for a moment about where they would place their progress on a line prior to calling out a yard marker. Each member noted significant progress on most areas, and their different perspectives on some of the problems led to helpful discussions about their various views of the changes made. Seeing the progress on the board, the son remarked, "Hey, we've done pretty good!" The father had tended to be cautious about acknowledging improvements during counseling, and the other family members were surprised at the significant progress he identified on the football grid. We went on to generate a list of specific things that each member had done to contribute to the family's progress and another list of steps that would maintain and further these gains. I provided these lists to the family as their "game plan" for continued progress and for review should a minor setback occur.

Use of Rituals

Rituals have been defined as collaborative, symbolic acts that address multiple meanings on behavioral, cognitive, and affective levels (Roberts, 1988). In terminating family counseling, rituals can be used to bring together therapeutic themes and to mark the closure of therapy. Rituals and certificates also can ease the transition from treatment to no treatment. The following sections highlight the use of rituals and certificates during the closing stages of therapy.

Evan Imber-Black (1999, pp. 207–209), a well-regarded and creative family therapist and trainer, offers an example of a ritual that assisted the family of Karen, a severely mentally retarded 22-year-old, when she left home. The family consisted of the parents, Karen, and her 20-year-old brother. The school Karen attended had been encouraging transition to a group home as a viable option, but the family had been reluctant to consider this. Conflict between Karen and her parents escalated as attempts were made to plan for the move to the group home. Using themes and language that had developed as counseling had progressed, the therapist devised a ritual that would mark Karen's young adulthood, promote the family's

confidence in her and themselves, and highlight ongoing connectedness among the members.

The parents and brother each were asked to choose a gift for Karen to take with her to her new home, a gift that would remind Karen of them and ease her adjustment to her new setting. Karen, in turn, was asked to select a gift for each family member. The gifts were not to be bought but rather something that belonged to them or that they had made. They were asked to bring these gifts to the next session and to keep secret what the gifts were.

The family arrived and appeared excited and happy in a way the therapist had not seen before. They had also agreed on a definite date for Karen to move out, something that they had not been able to do before. There was a lot of secretive laughter as family members went about preparing their gifts. Each person was instructed to share his or her gift and provide a brief explanation of its meaning. The recipient was instructed to respond simply "thank you." This format placed all family members on more even ground, gave Karen's limited verbal abilities, and focused on the giving of the gifts while limiting discussion.

Karen's father offered his gift first, his favorite frying pan with which he made Sunday breakfast on a regular basis. Karen had been learning to cook, and he had not let her use it for fear that she would ruin it. Karen beamed and said "thank you." Her mother gave her perfume and a pair of earrings that had belonged to Karen's grandmother, explaining that Karen was now grown up enough to have them (she had never allowed her to wear earrings previously). Teary-eyed, Karen said "thank you." Her brother, who was also moving out to go to college, gave Karen his pet bird and a box of birdseed. He had had pets over the years and had been responsible for them, whereas Karen had not. He promised to teach her to care for the bird before she moved out.

Karen then gave her gifts. To her mother she gave her favorite stuffed animal with which she still slept, saying that she could not sleep with it in her new home. To her father she gave a photograph of herself and several young men, which had been taken on one of her visits to the group home. She said to her father, "These are my new

friends." To her brother she gave her clock radio, a prized possession that had been a Christmas present, saying, "Don't be late for school!" Two weeks after the session, Karen moved into the group home, and a month later her brother left for college. The family ended therapy and at one-year follow-up reported that both children had adjusted well to their new settings and were visiting for the holidays. The mother had also returned to school to train for paid employment.

I (GHB) have also used a therapist-devised ritual for closure with a client. During the first session, which took place in the psychiatric wing of a local hospital, this middle-aged African American female had remarked after telling some of her story that I must think she was "a nut." I responded by assuring her that I did not think she was a nut but asked, if she were a nut, what kind she would be. She responded that she would be a Brazil nut. We utilized this metaphor at various times throughout her therapy, likening the thick, hard shell of the Brazil nut to her difficulty in allowing anyone to be very close, as well as to times when she might want to protect herself appropriately, the unique and rich taste of the Brazil nut to her talents and sense of self, and so on. For our final session, to her surprise, I brought in some Brazil nuts and nutcrackers, and we broke apart and ate Brazil nuts while discussing the gains she had made, the skills she had developed, and how she might maintain the progress she had made. This ritual also tapped her sense of humor, an important resource for her, and she thoroughly enjoyed this encounter during a closure session about which she had been feeling uneasy.

Other variations on the use of rituals for closure may involve having clients bring in symbols of the progress the family has made or of the efforts it will take to maintain their gains. Family members might also be asked to consider the specific things they and other family members have done to promote change, and to share these at a final session. Closure rituals generally necessitate a fairly formal final session and might not be appropriate in all cases. Also keep in mind that rituals should flow naturally from and be related to the themes and issues that have evolved over the course of therapy.

Use of Celebrations and Certificates

One of the most important tasks in reaching closure is for family members to highlight and underscore the positive changes that they have worked to achieve, and to reinforce that the identified client and the entire family are indeed different than they were when therapy started. A useful way to do this, particularly when the problem has been child-focused, is through the use of celebrations and certificates. These interventions come from narrative approaches to therapy (see, e.g., Freedman & Combs, 1996; White & Epston, 1990). Narrative therapy is based on theories of social constructionism and emphasizes the "stories" that are developed about people and circumstances. By deconstructing dominant, problem-saturated stories and reauthoring or building up more positive alternative stories, the therapist and family collaboratively work toward initiating and reinforcing change.

Narrative therapists frequently use questions in therapy to *externalize* the problem; that is, to place a problem that the client might view as an internal flaw or defect outside of the person (White & Epston, 1990). An example would be inquiring about times the client won the battle against depression and how he or she did so. Particularly in cases when a problem is child-related, externalization may also take on the form of personification, in which the problem is given a name and viewed as a force that the child and family can unite against and strategize about how to defeat. For instance, bed-wetting might be termed "Sneaky Wee," or problems with temper tantrums might be framed as times the child allows the "Tantrum Monster" to outwit him or her.

You can then make use of these externalizations to create official written documents or certificates for presentation to the child and family upon conclusion of counseling. These words appear on an official certificate signed by yourself and others, if appropriate. The text from an actual certificate (White & Epston, 1990, p. 194) offers a good example:

Beating Sneaky Wee Certificate

This certificate is granted to

_____

in recognition of his success at putting Sneaky Wee in its proper place.
_____ has turned the tables on Sneaky Wee. Sneaky Wee was running out on him. Now he has run out on Sneaky Wee. Instead of soaking in Sneaky Wee, he is soaking in glory.

Celebrations of positive change can occur along with the presentation of certificates or separately. They serve similar purposes of highlighting changes and congratulating family members for the efforts they have made to bring about those changes. Serving cake or cookies—or some other celebration that fits the family's culture—is a way to celebrate and mark the distinctions between the way things were when the family started in counseling and how they are now. A celebration can provide a fun and positive context for reinforcing the positive contributions of each family member, and can be used to identify helpful keys for maintaining progress. Narrative therapists also emphasize the importance of the identified client rallying others in his or her life who will support and strengthen the person's newly developing "story." Celebrations can serve the purpose of bringing those people together, uniting them in honoring the changes the client has made, and recommitting them to continue to assist in defeating the problem. For example, a closure session for a teenage girl on probation might involve her family members, probation officer, and school counselor. Each of these individuals could be invited to share in the celebration of her growth by noting signs of progress and identifying how he or she will support the girl's ongoing efforts to lead a new, responsible life.

Other strategies may be employed to reinforce the new status of

the client. The client or family may become "experts" in solving similar problems for others, and may even be included later as consultants in others' therapy. Narrative therapists also report on the development of support groups for people who have overcome a specific problem. For example, in some areas, clients who have struggled with anorexia have formed an Anti-Anorexia League (Freedman & Combs, 1996). This group offered a ready-made support system for those making the transition out of therapy, creating a new "audience" to reinforce their new status. They have also developed educational programs and projects to counter dominant cultural messages about body image and anorectics themselves.

After the "Final" Session

A useful termination should include some discussion about indications that a return to therapy is warranted. As mentioned previously, the family should have a plan to deal with predictable setbacks. In addition, you might agree with the family upon some conditions, such as a designated time frame or number of attempts to solve a recurring problem, after which the family would contact you again. As an example, sex therapist Barry McCarthy (1999, p. 298) has developed a relapse prevention plan for problems of low libido that includes the following behavioral conditions for returning to therapy: "If two weeks go by without sexual contact, the higher-desire spouse assumes responsibility for initiating a sexual date within the week. If the person does not do this, the lower-desire spouse takes responsibility to initiate a pleasuring or erotic date within the next week. If that does not occur, they schedule a therapy appointment. This promotes therapeutic adherence."

Another strategy for post-therapy follow-up is to offer the family the option of an initial phone consultation during which you can remind them of what has been helpful in the past or offer specific suggestions to address the problem at hand. Based on the results of this consultation, you may then suggest a return to counseling. There is a fine line between being available to clients in crisis and

empowering them to become increasingly self-reliant.

Some counselors routinely utilize pre-planned booster sessions to reinforce change and provide a sense of ongoing but less formal contact. Booster sessions are typically scheduled at three- or six-month intervals (Lebow, 1995). These sessions allow you to assess how well the family has maintained their prior gains, to renew old skills and insights, to reinforce the positive changes the family had made previously, and to instill hope and optimism. Booster sessions also provide a mini-evaluation of the need for a brief return to therapy. In some cases, particularly when a family is feeling reasonably good about progress but desires to maintain some connection with therapy, I (GHB) have scheduled a session for two or three months in the future, with the understanding that the family may call and cancel if they feel that things are going well. Some clients report feeling an added sense of security and confidence from knowing they have an appointment scheduled, even if they opt not to use it.

Unilateral Termination of Therapy

Closure is ideally a collaborative process between counselor and family. We do not do our family work in an ideal world, of course. Outside forces such as managed care restrictions and financial constraints may affect the length of treatment, even when both the therapist and family would like to continue. Other circumstances, such as the client or therapist moving or changing jobs, may necessitate an end to treatment before treatment goals have been reached. In many cases, treatment ends abruptly when the couple or family simply doesn't return. In other cases, the counselor may unilaterally recommend discontinuation of conjoint treatment for clinical reasons. These last two situations will be discussed in the following sections.

Client-Initiated Termination

Anyone working with families has experienced the frustration of getting a call from a family member indicating that he or she is

canceling an appointment and doesn't plan to reschedule. At other times clients simply do not show up and stop treatment without explanation. Some researchers suggest that client-initiated termination is more frequent in couples and family counseling than individual counseling (Lebow, 1995). Compared to the stable alliances common in individual counseling, alliances in family work are often more precarious, and more attention is often given to facilitating alliances among family members rather than between the counselor and the family. Sessions are frequently difficult and anxiety provoking because family members must face complaints about one another. A family approach involves multiple clients, who often vary in their motivation and desire to be in counseling A strong reaction to counseling from one family member may lead to abrupt termination. With the pace of modern life, it may become increasingly difficult to rally several family members to commit to a regular appointment time. For these reasons and others, some families opt to discontinue treatment suddenly. Finally, some cases of couples or family counseling hinge upon whether a partner wants to stay in the relationship or whether a family member plans to maintain contact with others in the family. Typically, a client's decision to leave the relationship or distance himself or herself from family members leads to the discontinuation of treatment.

In addition to understanding clients' reasons for termination, we do well to consider our own responses to premature terminations. Counselor reactions to client termination vary but often include blaming the family, blaming ourselves, and wondering what we might have done differently. It is important to remind ourselves that sudden terminations do not necessarily equal dissatisfaction with treatment. In a case study of premature termination related to my wife's dissertation (Helmeke, Bischof, & Sori, in press) a couple canceled their session and informed the therapist that they would not be returning. Due to the nature of the study, a follow-up interview was conducted. We learned, much to our surprise, that the couple had actually found counseling helpful, liked the counselor, and noted that the sessions had assisted them in clarifying that it would be best to

separate for a while. Counselors seldom have access to clients' perspectives on why they stop family work, but many report instances of clients who had discontinued therapy suddenly returning later (Patterson et al., 1998).

One of the challenges when clients leave treatment abruptly is to reach some sense of closure. Some family counselors advocate encouraging clients to return for a final wrap-up session and even informing clients at the beginning of counseling in a treatment disclosure statement that a concluding session is recommended or expected. Other alternatives are to attempt to ascertain the reasons why the clients stopped counseling through a phone call, and to present a case for returning to counseling if you believe there is more work to be done.

Our view is that it is not advisable to pursue families unduly when they have indicated a desire to terminate treatment. It is helpful to follow up initially by phone and to leave a message if possible. Because parents are typically responsible for making final decisions about continuing or discontinuing family counseling, we attempt to contact them first. Multiple calls may be warranted if there is no way to leave a message. After a few weeks, whether or not you have left a message, a letter is warranted. The letter should be positive, highlight the gains the family has made, and leave the door open for the family to decide to return in the future. It is also prudent to inform the family that you will be closing their case if you don't hear from them by a certain date, typically about two weeks from the date of the letter. Doing this helps make the status of the counseling less ambiguous. These strategies provide you and the family with at least some closure to the counseling experience. I (GHB) recall the admonition from my first clinical supervisor that "if you let families go easily, they will be more likely to return easily."

Therapist-Initiated Termination

There are likely to be occasional times when you cide unilaterally that treatment should be discontinued. Such instances include when families have become dependent upon counseling and are anxious

about going it alone, or when they seem to be using therapy as an excuse not to have to make real changes in their lives. Some of the strategies we discussed earlier about making a transition from regular sessions to closure apply here (e.g., spacing out sessions, preserving therapy hour without the therapist, etc.). Another strategy may be to limit the number of remaining sessions. Although the ultimate decision to end counseling may be a collaborative one, you may actively initiate open discussion about working toward a close of treatment in these kinds of cases.

Other clinical issues may suggest a need to terminate family treatment. One example is when there is an ongoing threat of family violence, and the perpetrator, victim, or other family members minimize or deny the violence. In such a case, continuing family treatment might actually increase the risk of further violence as the family members face issues more directly, leading to possible repercussions following treatment sessions. I (GHB) faced this situation in one memorable case. A couple who were cohabitating agreed that no physical violence had occurred in more than two years, but the male partner continued to deny and minimize his coercive threats and destruction of property. These behaviors had serious repercussions not only on his relationship with his partner but also the relationship between both adults and the female partner's eight-year-old son from a previous relationship. The male partner also began to dictate the structure of treatment sessions, demanding conjoint sessions and refusing to cooperate with the structured individual time within sessions that I was suggesting. I could not in good conscience continue treatment in this manner. I explained my rationale and referred the couple to individual or group treatment for domestic violence, with the possibility of conjoint treatment thereafter. The male was extremely unhappy with my decision, but the female seemed quietly pleased at seeing someone establish clear limits with her partner.

Conclusion

This chapter has addressed an often-neglected stage and process of family work. Closure of counseling, at its best, is a collaborative, mutually agreed upon process that contains elements throughout the counseling process as well as specific tasks to be addressed in the final stage of therapy. Work with families offers some unique challenges and opportunities related to ending counseling successfully.

In this chapter we have addressed common tasks associated with effective closure and have identified key issues at various points as counseling draws to a close. We have also included core elements of the closure session itself and have offered innovative interventions that involve the entire family and facilitate the process of successful closure. We have also suggested clarifying your availability after the final session and establishing guidelines for a return to counseling. Finally, we have discussed some of the issues involved when termination of counseling is initiated unilaterally.

Like much of our work with clients, there is probably more we could have said and other issues we might have addressed. But as we know, all things must come to an end. So, we say goodbye and wish you good endings. And if you are having difficulties you can't seem to handle on your own, you can call. . . .

References

Albom, M. (1997). *Tuesdays with Morrie: An old man, a young man, and life's greatest lesson.* New York: Doubleday.

Bell, J. E. (1975). *Family therapy.* New York: Aronson.

Brock, G. W., & Barnard, C. P. (1999). *Procedures in marriage and family therapy* (3rd ed.). Boston: Allyn and Bacon.

Carlson, R., & Carlson, K. (1999). *Don't sweat the small stuff in love.* New York: Hyperion.

Dreikurs, R. (1967). *Psychodynamics, psychotherapy, and counseling.* Chicago: Alfred Adler Institute of Chicago.

Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities.* New York: Guilford.

Hackney, H., & Cormier, S. (1994). *Counseling strategies and interventions* (4th ed.). Boston: Allyn and Bacon.

Heath, A. (1985). Ending family therapy—Some new directions. *Family Therapy Collections, 14,* 33–40.

Helmeke, K. B., Bischof, G. H., & Sori, K. (in press). Dropping out of couple therapy: A qualitative case study. *Journal of Couple and Relationship Therapy.*

Imber-Black, E. (1999). Creating meaningful rituals for new life cycle transitions. In B. Carter & M. McGoldrick (Eds.), *The expanded family life cycle: Individual, family, and social perspectives* (3rd ed., pp. 202–214). Boston: Allyn & Bacon.

Lebow, J. (1995). Open-ended therapy: Termination in marital and family therapy. In R. H. Mikesell, D. Lusterman, & S. H. McDaniel (Eds.), *Integrating family therapy: Handbook of family psychology and systems theory* (pp. 73–86). Washington, DC: American Psychological Association.

McCarthy, B. (1999). Relapse prevention strategies and techniques for inhibited sexual desire. *Journal of Sex and Marital Therapy, 25,* 297–303.

Mitchell, R. R., & Friedman, H. S. (1994). *Sandplay: Past, present and future.* Florence, KY: Taylor & Francis/Routledge.

Papero, D. V. (1995). Bowen family systems and marriage. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of couple therapy.* New York: Guilford.

Patterson, J., Williams, L., Grauf-Grounds, C., & Chamow, L. (1998). *Essential skills in family therapy: From the first interview to termination.* New York: Guilford.

Roberts, J. (1988). Setting the frame: Definition, functions, and typology of rituals. In E. Imber-Black, J. Roberts, & R. Whiting (Eds.), *Rituals in families and family therapy* (pp. 3–46). New York: Norton.

Seligman, L. (2001). *Systems, strategies, and skills of counseling and psychotherapy.* Upper Saddle River, NJ: Prentice Hall.

Treacher, A. (1989). Termination in family therapy—Developing a structural approach. *Journal of Family Therapy, 2,* 135–147.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends.* New York: Norton.

Wilcoxon, S. A., & Gladding, S. T. (1985). Engagement and termination in marital and familial therapy: Special ethical issues. *American Journal of Family Therapy, 13*(4), 65–71.

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)

NOTICE

Reproduction Basis

[ ] This document is covered by a signed "Reproduction Release (Blanket)" form (on file within the ERIC system), encompassing all or classes of documents from its source organization and, therefore, does not require a "Specific Document" Release form.

[X] This document is Federally-funded, or carries its own permission to reproduce, or is otherwise in the public domain and, therefore, may be reproduced by ERIC without a signed Reproduction Release form (either "Specific Document" or "Blanket").